DEPARTMENT OF PUBLIC HEALTH
DRUG CONTROL PROGRAM
www.mass.gov/dph/dcp
COMPLAINT FORM

Date Received (stamp):

Please complete this form as fully as possible. Please type or print legibly in ink.

COMPLAINT BY:

Name: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____
Number Street Daytime Phone

_____ _____ _____ _____
City State Zip Code Evening Phone

Best way to reach you: ☐Evening Phone ☐Daytime Phone ☐E-mail:_____

COMPLAINT AGAINST (use separate form for each business or individual):

Name: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____
Number Street Daytime Phone

_____ _____ _____ _____
City State Zip Code Profession

_____
Business Name

_____ _____
Business Address Daytime Phone

_____ _____ _____ _____
City State Zip Code Business Type

Description of the Complaint:

Briefly describe the incident that led to your complaint and note the times and dates that events occurred. List the names of all individuals involved. Please attach additional pages if needed.

_____

_____

_____

_____

_____

_____

I attest that the information provided is true, correct and complete to the best of my knowledge.

_____ _____
Complainant signature Date

Mail this form to: Department of Public Health, Drug Control Program, 305 South Street, Jamaica Plain, MA 02130
Of fax form to: (617) 524-8062 Tel. (617) 983-6700